WISCONSIN HEMOPHILIA HOME CARE PROGRAM
APPLICATION INSTRUCTIONS

The Wisconsin Chronic Disease Program (WCDP) is a state-funded program whose purpose is to provide payment for chronic renal disease, adult cystic fibrosis and hemophilia home care supplies. The WCDP provides payment after all other payment sources have been used.

Completion of this application is voluntary. However, if it is not completed, your eligibility for benefits cannot be determined. The Department of Health and Family Services has the authority to collect personally identifiable information necessary to determine continued eligibility and benefits for the Wisconsin Chronic Disease Program. The personally identifiable information collected on this application will only be used to determine eligibility and benefits. Provision of your social security number is voluntary, however, your social security number is one of the unique identifiers used to identify you as a unique person in our claim system. Applicants who need assistance completing their application should contact their treatment facility social worker.

Upon determination that an applicant is eligible for WCDP benefits, the applicant receives a letter of notification, and a WCDP identification card. WCDP participants are required to inform WCDP of any qualifying changes such as change in address, eligibility, mode of treatment, health insurance coverage, Medicare coverage, an up or down income change of more the 10%, or change in family size. Within 30 days of any qualifying change in circumstance, the WCDP participant is responsible for submitting any qualifying change(s) in writing to the WCDP. WCDP participants may be responsible for income deductibles, inpatient/outpatient deductibles, drug copayments, and coinsurance.

Instructions

Print clearly and follow these instructions carefully. Incomplete or illegible applications will be returned and delay determination of your eligibility. If you are an applicant's representative, provide the applicant's information. Make a copy of your completed application for your records.

SECTION 1. APPLICANT INFORMATION

Item 1. Print your last name, first name and middle initial.
Item 2. Indicate your Social Security Number.
Item 3. Indicate your street address. You must indicate the physical residential address. A post office box alone is not acceptable.
Item 4. Indicate your home telephone number including the area code. If you do not have a telephone, indicate "None."
Item 5. Indicate your city, state and zip code.
Item 6. Indicate the county where you live.
Item 7. Check "Male" or "Female".
Item 8. Indicate the month, date and year of birth.
Item 9. Answer "Yes" if you have dependent family members who are participants of the Wisconsin Chronic Disease Program. If you answered "Yes", indicate the name(s) and Social Security Number(s) of all dependent family members currently eligible for benefits from the Chronic Disease Program.
Item 10. Indicate your race/ethnicity by checking the appropriate box. This information will be used for statistical purposes only.

SECTION 2. RESIDENCY INFORMATION

Item 11. Check "Yes" or "No." If you answered "No", indicate the month, date, and year you moved to Wisconsin.

Item 12a. Applicants age 19 and over should provide copies of the following documents:

- Last year's Wisconsin Income Tax return with all attachments.
- The most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address **OR** state identification with current address.
- Alien registration card issued by the INS if you are not a U.S. citizen.

Item 12b. Applicants under the age of 19 should provide copies of the following documents.

- Parent's or guardian's Wisconsin Income Tax return with all attachments for the last year.
- Parent's or guardian's most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address **OR** state identification with current address **OR** school identification.
- Alien registration card issued by the INS if you are not a U.S. citizen.

Item 13. If you do not have these documents, explain why. Attach additional pages if necessary.

SECTION 3. MEDICARE AND WISCONSIN MEDICAID INFORMATION

Item 14. Check "Yes" or "No."
If you answered Yes, indicate your Medicare Part A (hospital insurance) and Part B (medical insurance) begin date(s). If your coverage has ended, indicate the end date(s). *If you currently have Medicare coverage, do not indicate a Medicare end date.* If you answered "No", proceed to item 15.

Item 15. Check "Yes" or "No."
If "Yes", indicate your Wisconsin Medicaid, BadgerCare or SeniorCare identification number. Wisconsin Medicaid may also be called Medical Assistance, MA, Title 19 or T-19.

Item 16. Check "Yes" or "No" to indicate whether you have applied for Wisconsin Medicaid, BadgerCare or SeniorCare in the past year, if you answered no in item 15.
If "Yes", explain why you were denied eligibility for Medicaid, BadgerCare or SeniorCare.
Wisconsin law requires applicants must first complete applications for other health care programs, if they may be reasonably eligible given their financial and non-financial circumstances, before applying to WCDP.

SECTION 4. SOCIAL WORKER SIGN OFF

Item 17. This section should be completed by a health professional who is involved with the care of the applicant if the applicant has not applied for Wisconsin Medicaid, BadgerCare or SeniorCare.

SECTION 5. INSURANCE INFORMATION

Item 18. Check "Yes" or "No" to indicate whether you have private, group, HIRSP (Health Insurance Risk Sharing Plan) or other health insurance coverage for medical expenses. Do not include Medicare, Wisconsin Medicaid or BadgerCare, or the Wisconsin Chronic Disease Program here.
If "Yes", complete items 18a through 18o.

a. Indicate the name of the company through which you have health insurance coverage.
b. Indicate the telephone number, including the area code of the insurance company.
c. Indicate the name of the policyholder.
d. Indicate your relationship of the policyholder to you (e.g. wife, husband, self).
e. Indicate the policy number.
f. Indicate the group policy number.
g. Indicate the date the coverage began.
h. Indicate the date the coverage ended if you no longer have the coverage. If the coverage is still in effect, leave the coverage termination date blank.

i-o. Check "Yes" or "No" for each question. Refer to your insurance policy or contact your insurance company or representative for more information on your coverage.

If you have more than one insurance company, list the second insurance under "Insurance #2." Attach additional information if needed for current and past insurance for the last two years.

SECTION 6. FINANCIAL INFORMATION.

Item 19. Indicate the number of dependent family members; include yourself if you are a dependent family member. Include all family members who may be claimed as dependents by the applicant for the purpose of filing a federal income tax return. This information is needed to determine your deductible for the Hemophilia Home Care program.

Item 20. Indicate your average total income by completing items a - l. Choose to complete either the average monthly totals OR annual totals.

If you are completing the "Average Monthly Totals" column, indicate the income received during a month in the most recent 12-month period. Do not use the highest or lowest monthly totals for income, use a monthly total that reflects an average amount of income. Indicate the month and year of this income (e.g. March 2004). If you are completing the "Annual Totals" column, indicate the income for the most recently completed calendar year. Indicate the calendar year of this income (e.g. 2003).

- **If you are claimed as a dependent on someone else's income tax return**, enter the current total monthly or annual income from that person's paycheck stub and enter all federal social security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (e.g. W-2 payments), pensions, annuities, veteran's benefits, unemployment compensation, worker's compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation received by that person. **Also, include any of these same types of payments or income received by you and everyone included in Item 19.**

- **If you are not claimed as a dependent by anyone else on their income tax return, but file your own income tax return and claim yourself as an exemption**, enter the current total monthly or annual income from your paycheck stub and enter all federal social security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (e.g. W-2 payments), pensions, annuities, veteran's benefits, unemployment compensation, worker's compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation **received by you and everyone included in Item 19.**

- **If you are not claimed as a dependent by anyone else on their income tax return, and you do not file an income tax return of your own**, enter the current total monthly or annual income from your paycheck stub, all federal Social Security payments, dividends, interest income, estate or trust income, net rental income, royalties, cash public benefits (e.g. W-2 payments), pensions, annuities, veteran's benefits, unemployment compensation, worker's compensation, maintenance payments, alimony, child support, nontaxable interest, and nontaxable deferred compensation **received by you and everyone included in Item 19.**

Item 20m. Add up the amounts in items 20a through 20l. and indicate the current total monthly or annual income.

Item 21. Indicate whether you anticipate your monthly income to increase or decrease more than 10%. If your monthly or annual income increases or decreases more than 10%, you must notify in writing the Wisconsin Chronic Disease Program of the change within 30 days.

Item 22. If you answered yes in item 21 explain why.

Item 23. Indicate your total gross family income based on last year's Wisconsin Income Tax return. If you did not file a state tax return leave this area blank.

SECTION 7. AGREEMENT AND SIGNATURES

Item 24. Indicate the medical facility from which you are receiving treatment.

Item 25. Enter signatures and date signed for applicant or applicant's representative if applicant is a minor.

SECTION 8. HEMOPHILIA HOME CARE PATIENT MEDICAL INFORMATION

Section 8 is to be completed by the appropriate medical professional.

Send the completed form to:

Wisconsin Chronic Disease Program
Attention: Eligibility Unit
P.O. Box 6410
Madison, WI 53716-0410

If you have questions regarding the completion of this application, please contact your treatment center social worker or call the Chronic Disease Program at (608) 221-3701.

Did you remember to:

- Sign and date the application.
- Include a copy of last year's Wisconsin Income Tax return with all attachments.
- Include a copy of the most recent rental agreement OR property tax bill.
- Include a copy of your Wisconsin driver's license with current address OR state identification with current address OR Student ID (only for applicants under age 19).
- Include a copy of your Alien registration card issued by the INS if you are not a U.S. citizen.

CAUTION: Failure to fully complete your application and provide the requested documentation may result in delayed processing and eligibility determination.

WISCONSIN HEMOPHILIA HOME CARE PROGRAM
LIABILITY CHART

Liability for Services Received on July 1, 2004 and After Based on Current Policies

Liability Based on Percent of Charges:

ANNUAL FAMILY INCOME	PERCENT OF CHARGES FOR WHICH PARTICIPANT IS LIABLE, BY FAMILY SIZE									
	Number of Dependent Family Members *									
	1	2	3	4	5	6	7	8	9	10
$ 0 - 7,000	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
7,001 - 10,000	2	1	0	0	0	0	0	0	0	0
10,001 - 15,000	3	2	1	0	0	0	0	0	0	0
15,001 - 20,000	4	3	2	1	0	0	0	0	0	0
20,001 - 25,000	5	4	3	2	1	0	0	0	0	0
25,001 - 30,000	14	5	4	3	2	1	0	0	0	0
30,001 - 35,000	17	13	5	4	3	2	1	0	0	0
35,001 - 40,000	20	16	6	5	4	3	2	1	0	0
40,001 - 45,000	24	19	15	6	5	4	3	2	1	0
45,001 - 50,000	29	24	20	17	6	5	4	3	2	1
50,001 - 55,000	34	29	25	21	7	6	5	4	3	2
55,001 - 60,000	39	34	29	25	23	7	6	5	4	3
60,001 - 65,000	44	39	34	30	28	25	7	6	5	4
65,001 - 70,000	49	44	39	35	32	29	8	7	6	5
70,001 - 75,000	55	49	44	40	37	34	32	8	7	6
75,001 - 80,000	61	55	50	46	43	40	37	35	7	6
80,001 - 85,000	67	61	56	52	49	46	43	40	7	6
85,001 - 90,000	74	68	63	59	56	53	50	47	45	6
90,001 - 95,000	81	75	70	66	63	60	57	55	53	51
95,001 -100,000	88	82	77	73	70	67	64	62	60	58
100,000+	97	91	86	82	79	76	73	71	69	67

Annual Cap Amount on Liability:

Annual Income	"Cap" Percent
Up to - $10,000	3%
$10,001 - $20,000	4%
$20,001 - $40,000	5%
$40,001 - $60,000	6%
$60,001 - $80,000	7%
$80,001 - $100,000	9%
$100,001 - and up	10%

* To determine who is a dependent family member, refer to the Application or Financial Need Statement Instructions.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
PHC 1191 (Rev. 02/04)

WISCONSIN CHRONIC DISEASE PROGRAM
INCOME DEDUCTIBLE

Under current policy, if your anticipated total family annual income is greater than or equal to 200% of the Federal Poverty Level (FPL), you are required to pay a percent of your income as out-of-pocket expense before the Wisconsin Chronic Disease Program will reimburse your medical expenses. This out-of-pocket expense is your income deductible.

The income deductible percentage is based on a formula using the FPL and the family size and income level you report to the Chronic Disease Program each year in the Financial Need Statement. To determine your percent of income deductible, refer to the income deductible charts.

For example, assume that you have an annual income of $30,000 and a family size of two. Your income deductible is .50% of $30,000 or $150. You must pay $150 out-of-pocket for eligible medical expenses before the Chronic Disease Program can begin to reimburse providers. You may calculate your own income deductible using the tables below. Contact your social worker or the Chronic Disease Program for assistance if needed.

Income Deductible is 0.50% of Family's Annual Income

200% - 250% of 2004 FPL	Family Size
$18,620 - 23,275	1
$24,980 - 31,225	2
$31,340 - 39,175	3
$37,700 - 47,125	4
$44,060 - 55,075	5
$50,420 - 63,025	6
$56,780 - 70,975	7
$63,140 - 78,925	8
$69,500 - 86,875	9
$75,860 - 94,825	10

Income Deductible is .75% of Family's Annual Income

251% - 275% 2004 FPL	Family Size
$23,275.01 - 25,602.50	1
$31,225.01 - 34,347.50	2
$39,175.01 - 43,092.50	3
$47,125.01 - 51,837.50	4
$55,075.01 - 60,582.50	5
$63,025.01 - 69,327.50	6
$70,975.01 - 78,072.50	7
$78,925.01 - 86,817.50	8
$86,875.01 - 95,562.50	9
$94,825.01 - 104,307.50	10

Income Deductible is 1.00% of Family's Annual Income

276% - 300% 2004 FPL	Family Size
$25,602.51 - 27,930	1
$34,347.51 - 37,470	2
$43,092.51 - 47,010	3
$51,837.51 - 56,550	4
$60,582.51 - 66,090	5
$69,327.51 - 75,630	6
$78,072.51 - 85,170	7
$86,817.51 - 94,710	8
$95,562.51 - 104,250	9
$104,307.51 - 113,790	10

Income Deductible is 1.25% of Family's Annual Income

301% - 325% of 2004 FPL	Family Size
$27,930.01 - 30,257.50	1
$37,470.01 - 40,592.50	2
$47,010.01 - 50,927.50	3
$56,550.01 - 61,262.50	4
$66,090.01 - 71,597.50	5
$75,630.01 - 81,932.50	6
$85,170.01 - 92,267.50	7
$94,710.01 - 102,602.50	8
$104,250.01 - 112,937.50	9
$113,790.01 - 123,275.50	10

Income Deductible is 2.00% of Family's Annual Income

326% - 350% 2004 FPL	Family Size
$30,257.51 - 32,585	1
$40,592.51 - 43,715	2
$50,927.51 - 54,845	3
$61,262.51 - 65,975	4
$71,597.51 - 77,105	5
$81,932.51 - 88,235	6
$92,267.51 - 99,365	7
$102,602.51 - 110,495	8
$112,937.51 - 121,625	9
$123,275.51 - 132,755	10

Income Deductible is 2.75% of Family's Annual Income

351% - 375% 2004 FPL	Family Size
$32,585.01 - 34,912.50	1
$43,715.01 - 46,837.50	2
$54,845.01 - 58,762.50	3
$65,975.01 - 70,687.50	4
$77,105.01 - 82,612.50	5
$88,235.01 - 94,537.50	6
$99,365.01 - 106,462.50	7
$110,495.01 - 118,387.50	8
$121,625.01 - 130,312.50	9
$132,755.01 - 142,237.50	10

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
PHC 1190 (Rev. 02/03) (Formerly PHC 0802)

Income Deductible is 3.50% of Family's Annual Income

376% - 400% of 2004 FPL	Family Size
$34,912.51 - 37,240	1
$46,837.51 - 49,960	2
$58,762.51 - 62,680	3
$70,687.51 - 75,400	4
$82,612.51 - 88,120	5
$94,537.51 - 100,840	6
$106,462.51 - 113,560	7
$118,387.51 - 126,280	8
$130,312.51 - 139,000	9
$142,237.51 - 151,720	10

Income Deductible is 4 .50% of Family's Annual Income

Greater than 400% 2004 FPL	Family Size
Greater than $37,240.01	1
Greater than $49,960.01	2
Greater than $62,680.01	3
Greater than $75,400.01	4
Greater than $88,120.01	5
Greater than $100,840.01	6
Greater than $113,560.01	7
Greater than $126,280.01	8
Greater than $139,000.01	9
Greater than $151,720.01	10

DEPARTMENT OF HEALTH & FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING
HCF 1184 (Rev. 02/04)

STATE OF WISCONSIN
ss. 49.685 WIS STATS

WISCONSIN HEMOPHILIA HOME CARE PROGRAM APPLICATION

READ INSTRUCTIONS CAREFULLY BEFORE COMPLETING THE FORM

SECTION 1. APPLICANT INFORMATION

1. Name – Applicant (Last, First, MI)	2. Social Security Number (SSN) (optional)
3. Street Address – Applicant	4. Home Telephone
5. City, State, ZIP Code	6. County of Residence
7. Sex ☐ Male ☐ Female	8. Date of Birth

9. Do you have any dependent family members who are participants of the Chronic Disease Program? ☐ Yes ☐ No
If Yes, indicate the names and Social Security Numbers (SSN) of all dependent family members who are participants of the Chronic Disease program.

Name _____ SSN _____

Name _____ SSN _____

10. Race/Ethnicity (Optional)
☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Hispanic (Mexican, Puerto Rican, Cuban or other Hispanic Culture)
☐ Black (Not of Hispanic Origin) ☐ White (Not of Hispanic Origin)

SECTION 2. RESIDENCY INFORMATION

11. Have you lived in Wisconsin for the last 2 years? ☐ Yes ☐ No
If you answered No, indicate the date you moved to Wisconsin_____.

12a. Applicants age 19 and over should provide copies of the following documents.
- Last year's Wisconsin Income Tax return with all attachments.
- The most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address OR state identification with current address.
- Alien registration card issued by the ISN if you are not a U.S. citizen.

12b. Applicants under the age of 19 should provide copies of the following documents.
- Parent's or guardian's Wisconsin Income Tax return with all attachments for the last year.
- Parent's or guardian's most recent rental agreement or property tax bill.
- Wisconsin driver's license with current address OR state identification with current address OR school identification.
- Alien registration card issued by the ISN if you are not a U.S. citizen.

13. If you do not have these documents, explain why.

SECTION 3. MEDICARE AND WISCONSIN MEDICAID INFORMATION

14. Do you currently have or have you had Medicare coverage? ☐ Yes ☐ No
If yes, indicate your Medicare eligibility dates below.

Part A (Hospital) – Begin Date _____ Part B (Medical) – Begin Date _____

Part A – End Date _____ Part B – End Date _____

If you are currently eligible for Medicare, attach a copy of your Medicare card.

15. Wisconsin law requires applicants must first complete applications for other health care programs, if they may be reasonably eligible given their financial and non-financial circumstances, before applying to WCDP.
Are you currently enrolled in Wisconsin Medicaid (Medical Assistance, MA, Title 19, T-19), BadgerCare or SeniorCare?
☐ Yes ☐ No

If yes, indicate your Medicaid, BadgerCare or SeniorCare identification number here_____.

16. If no, have you applied for any of these programs in the past year? ☐ Yes ☐ No

If yes, and you were denied eligibility for these programs, explain why.

_____.

SECTION 4. SOCIAL WORKER SIGN OFF

This section is to be completed by a healthcare professional if the applicant is **not** enrolled in Wisconsin Medicaid, BadgerCare or SeniorCare.

17. Based on my knowledge of _____, I attest that he/she is not eligible for the programs listed above. Explain in the space provided why the applicant would be denied eligibility, where applicable.

Medicaid _____.

BadgerCare_____.

SeniorCare_____.

SIGNATURE – Healthcare Professional	**Facility Name**	**Date Signed**

SECTION 5. INSURANCE INFORMATION

18. In the last two years have you had or do you currently have private, group, HIRSP, or other health insurance coverage for medical expenses? (Do not include Medicare, Medicaid or BadgerCare information here.) ☐ Yes ☐ No

If yes, complete the following information. If you have more than one insurance company, list the second company under Insurance 2. Attach additional information if needed for current and past insurance for the last two years.

Insurance #1		Insurance #2	
a. Name – Insurance Company	b. Telephone Number	a. Name – Insurance Company	b. Telephone Number
c. Name – Policy Holder	d. Relationship of Policy Holder	c. Name – Policy Holder	d. Relationship of Policy Holder
e. Policy Number	f. Group Policy Number	e. Policy Number	f. Group Policy Number
g. Coverage Begin Date	h. Coverage Termination Date	g. Coverage Begin Date	h. Coverage Termination Date
Indicate whether this insurance covers these services by answering each question. Answer each question.		Indicate whether this insurance covers these services by answering each question. Answer each question.	
i. Inpatient Hospital Service. ☐ Yes ☐ No		i. Inpatient Hospital Service. ☐ Yes ☐ No	
j. Outpatient Hospital Service. ☐ Yes ☐ No		j. Outpatient Hospital Service. ☐ Yes ☐ No	
k. Physician Services. ☐ Yes ☐ No		k. Physician Services. ☐ Yes ☐ No	
l. Radiology Services. ☐ Yes ☐ No		l. Radiology Services. ☐ Yes ☐ No	
m. Laboratory Services. ☐ Yes ☐ No		m. Laboratory Services. ☐ Yes ☐ No	
n. Hemophilia home care products and supplies. ☐ Yes ☐ No		n. Hemophilia home care products and supplies. ☐ Yes ☐ No	
o. Prescription Drugs. ☐ Yes ☐ No		o. Prescription Drugs. ☐ Yes ☐ No	

SECTION 6. FINANCIAL INFORMATION

19. Indicate the number of dependent family members; include yourself if you are a dependent family member. _____

20. Indicate your current total income by completing items a - m either by **monthly OR annual totals.**	Average Monthly Totals _____ Month 2 0 __ __ Year **OR**	Annual Totals 2 0 __ __ Year
a. Gross wages, salaries, tips, etc.	$	$
b. Net income from non-farm self-employment.	$	$
c. Net income from farm self employment.	$	$
d. Social Security and/or Supplemental Security benefits.	$	$
e. Dividends and interest income.	$	$
f. Total of estate or trust income, net rental income and royalties.	$	$
g. Cash public benefits (e.g. W-2 payments).	$	$
h. Pensions, annuities and/or veteran's pension.	$	$
i. Unemployment compensation and/or worker's compensation.	$	$
j. Maintenance, alimony and/or child support.	$	$
k. Non taxable interest (federal, state or municipal bonds).	$	$
l. Nontaxable deferred compensation.	$	$
m. Total Monthly OR Yearly Income.	$	$

21. Do you expect this income to change significantly from month to month or in the next year? ☐ Yes ☐ No

22. If yes, will your income be less or more than the total above? ☐ Less ☐ More
Explain why.

23. On last year's Wisconsin Income Tax return, what was your total gross family income before taxes? _____.

SECTION 7. AGREEMENT AND SIGNATURES FOR HEMOPHILIA HOME CARE APPLICANTS

Eligibility for state reimbursement exists only insofar as certified by the Department of Health and Family Services (herein called the Department) or its fiscal agent upon: a) recipient of completed application, including verification by the physician director of the participant's successful participation in a hemophilia home care or self-infusion training program and maintenance program; and c) existence of a written agreement, as designated by the Department or its fiscal agent, between the patient and a certified comprehensive treatment center for compliance with the maintenance program.

Pursuant to the authority of Wisconsin Statute 49.685 and 49.687 and the rules promulgated thereunder, the Department or its fiscal agent will, subject to the conditions named, reimburse a certified comprehensive hemophilia treatment center or an approved source, on behalf of the participant, for part of the cost of hemophilia home care blood products and infusion supplies. Reimbursement will be made only for that portion of the allowable cost of home care blood products and infusion supplies remaining after all payment from other state programs, federal programs, and private health insurance coverage have been received and the participant's liability and deductibles have been determined. The participant's liability and deductibles will be based on income and family size.

Wisconsin Administrative Code 153 specifies the methodology for provider reimbursement. **Charges in excess of what the Hemophilia Home Care Program allows are the individual responsibility of the participant.**

If insufficient aid is available from other sources, the state shall pay the difference between the allowable cost and the sum of payment received and participant liability and deductibles. State payment shall be appropriately reduced if federal, state, private or other health insurance becomes available during the benefit period. The participant must inform the Department or its fiscal agent of all health insurance coverage and eligibility date.

The Department, the State of Wisconsin, and its officers or agents are released and discharged of and from all manner of action and actions, cause and causes of actions, suits, sums of money, judgment, claims, and demands whatsoever in law or in equity which the claimant, or his/her heirs, executors or assignees might have, or may hereinafter have, by reason of any injury or worsening of condition or death of the participant due to treatment of hemophilia or lack of treatment.

In order to establish my eligibility for state benefits, I authorize the medical facility (24)_____ to disclose information relating to my health condition or payment made for my health care to the Hemophilia Home Care Program.

I certify, to the best of my knowledge, all information provided on this form is true, correct, and complete. I understand that I will be denied reimbursement if I withhold information, provide inaccurate information, or refuse to provide information. I authorize release of any medical and financial information including certification for General Assistance, Medicaid or Medicare to the Wisconsin Chronic Disease Program necessary for processing claims and verifying services under the program. I agree to notify the Department or its fiscal agent in writing within 30 days of any change in name, address, income by more than 10%, insurance coverage, or family size. I agree to accept responsibility for the program's copayments and deductibles. I have read and consent to the above.

I understand that benefits issued through the Wisconsin Chronic Disease Program are eligible for estate recovery as defined in HFS 153.07(5). I understand that only Wisconsin residents are eligible for the Chronic Disease Program. By signing this form I am attesting that I am a Wisconsin resident as set forth in HFS 153.02(17).

25. SIGNATURE – Applicant (or applicant's representative if applicant is a minor)	Date Signed

SECTION 8. HEMOPHILIA HOME CARE PATIENT MEDICAL INFORMATION

Section 8 is to be completed by Hematologist at approved comprehensive hemophilia treatment center.

26. Name – Patient (Last, First, MI)	27. Patient's primary diagnosis (Use ICD-9-CM code)
28. Specific laboratory factor assay result _____.	29. Date Performed _____ .
30. Name – Treating Facility	31. Medicaid Provider identification number of facility

32. Address – Treating Facility

I hereby certify that the above-named patient is a successful participant in a hemophilia home care or self-infusion training program. The initial date of the patient's successful participation was (33) _____. I accept the responsibility for reviewing the established maintenance program every six months and understand that I may be required to verify that this patient continues to comply with the program.

34. **SIGNATURE** – Physician Director	Date Signed

Send completed application to:

Chronic Disease Program
Attn: Eligibility Unit
P.O. Box 6410
Madison, WI 53716-0410

OFFICE USE ONLY. DO NOT WRITE IN THIS SPACE.